HART COUNSELING SERVICES, PLLC

15901 Central Commerce Dr. Ste # 506
Pflugerville, TX 78660

Phone: (512) 518-1920 ❤ Fax: (512) 777-2982

Counseling Intake Form

Please complete this form as best you can. This information is confidential and is designed to help me learn a little more about you and help our time together be as productive as possible.

Client Information

Today's date: ___________

First and Last Name: ____

Preferred name: ___________________________

Date of Birth: ___________

How do you describe your gender identity? ________________________

Preferred gender pronoun (ex: he, him, she, her, all pronouns)? ____________________

How do you describe your sexual orientation? ___________________________________

How do you describe your racial/ethnic heritage? ________________________________

How can I reach you?

Best Contact number: ___________________

Can I call you? Yes / No

Leave a message? Yes / No

Texting - **limited to emergency scheduling issues only** -Yes / No

Can I email you? Yes / No

Email Address: ____

Employer/occupation: ______________________________________

Residence Address: _____________________ City/Zip: ___________________________

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Marital Status

Married / Separated / Divorced / Partnered / Single

How long? ____________

Spouse/Partner's name: ____

Spouse/Partner's age: _______

Children: Yes / No

Name: ________________________________ Age: _____

Name: ________________________________ Age: _____

Name: ________________________________ Age: _____

Name: ________________________________ Age: _____

Name: ________________________________ Age: _____

Presenting Concern

Briefly tell me what brings you in today?

____

____

____

____

How have you managed this concern up to this point?

____

____

____

____

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In what way do you hope, as your counselor, I can help you?

____

____

____

____

When was the last time you had a good belly laugh?

____

____

____

____

Background information:

Family Relationships

Father's Name: ________________ Age: ____ (Living or Deceased)

Mother's Name: ________________ Age: ____ (Living or Deceased)

Siblings: Yes / No

Name: ______________________________ Age: _____

Name: ______________________________ Age: _____

Name: ______________________________ Age: _____

Name: ______________________________ Age: _____

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Other Siblings, Significant Persons and/or Relationships:

____

____

____

____

____

Health Related Concerns

Rate your health: Very Good __ Good __ Average __ Declining __ Poor __

Major Illness (Past or Present):

____

____

____

Surgeries: ____

Injuries: ____

Have you ever received any type of mental health services? Yes / No

If yes, what type: (check all that apply)

___ Therapy - group/individual

___ Medication

___ Inpatient Hospitalization

Briefly describe what the experience was like for you? What did you like/not like?

____

____

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Have you ever received a psychiatric diagnosis? Yes / No

If yes, please name the diagnoses and/or any current medications:

____

____

____

Substance Use History

Do you have an addiction? Yes ____ No ____ Uncertain ____

Have you used drugs for reasons other than medical purposes? Yes/No

When? ____________

What? ____________________________

Frequency/Amount: ______________________________

Do you drink alcoholic beverages? Yes/No

Frequency: _______________________

Is there anything else you want me to know?

____

____

____

____

____

If applicable:
How did you find me? Referral source: _________________________

Thank you for completing this form. Please allow me a few moments to review it and then we can get started. - Jenn